STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
Wednesday, November 19, 2014

Members Present: Rohit Bhalla; Aileen Broderick; Mehul Dalal; Deb Dauser Forrest; Daniela Giordano; Karin Haberlin; Elizabeth Krause; Kathy Lavorgna; Steve Levine; Arlene Murphy; Robert Nardino; Donna O'Shea; Meryl Price; Jean Rexford; Andrew Selinger; Steve Wolfson; Thomas Woodruff

Members Absent: Gregory Barbiero; Mark DeFrancesco; Kathleen Harding; Gigi Hunt; Rebecca Santiago; Todd Varricchio

Other Participants: Michael Hunt; Joseph Quaranta; Mark Schaefer; C. Todd Staub

Meeting was called to order at 6:17 p.m.

1. Call to order
Mehul Dalal chaired the meeting. Members introduced themselves.

2. Public Comment
There was no public comment.

3. Minutes
Due to the late start, the Council tabled voting on the September 23rd minutes until the next meeting.

4. ACO Presentations
Mark Schaefer provided context for the presentations. Medicare is currently the only organization with 60% of its scorecard based on self-reported methods generated through electronic health records. The Council will look at whether there are ways to expand the accountable care organization approach. Dr. Schaefer noted that some health plans have raised questions regarding program integrity. ACO representatives have been invited to present on their experiences.

C. Todd Staub presented on behalf of ProHealth Physicians (see presentation, measures chart, and quality performance report). Jean Rexford asked Dr. Staub what he had seen that is positive. He said that ACOs cannot go into the process naively as it is quite complicated. None of the ACOs in the state have saved money which requires hitting quality metrics and cost savings. He said he did think it was possible. ProHealth is aiming to go to a full risk model by 2016. They have seen reduced readmissions and emergency room utilization. Their electronic health records system is tuned in such a way that patients can view their information, correct errors, and communicate with the medical staff. He noted that accessing data for reporting has been a challenge. There are issues with data fields where smoking cessation or colonoscopies are not appropriately documented. This leads to a great deal of manual processing. Dr. Dalal asked what was most likely to evolve as they move to full risk. Dr. Staub said there was no simple technology solution. He said there would be more than just eight measures and a great deal of risk stratification. He said they will need to link with community-based institutions to look at ways to get to the social determinants of health. Coordinated spending on both clinical care and the social safety need are needed. Arlene Murphy asked if different providers used different systems. Dr. Staub said that the metrics are payer based. He noted that gathering data at the state level will be important. He recommended they look at technology companies that could help stitch the disparate parts of the system together and not to exclude newer companies.

Michael Hunt spoke on behalf of St. Vincent's Health Partners (see St. Vincent's Health Partners presentation here). Dr. Bhalla said the presentation is illustrative of the challenges ahead. He asked how the Physician Quality Reporting System (PQRS) facilitated the process. Dr. Hunt said that starting in 2015, if a practice does

not submit PQRS data, their payments are adjusted. He said that ACOs are woefully under-adapted to submit all of the PRQS data and that they have shied away from measures requiring biometric EHR data. In 2015, measures will require an outcome; claims based data alone will not be successful. He said they can submit manually but in a group of 25 or more, they need a registry certified by CMS which can be costly. They have tried to align their organization to ACO metrics and place PQRS underneath it. Dr. Schaefer asked whether it would be a good thing if they adopted many of the 33 Medicare measures. Dr. Hunt said it is not a technological problem if they limit the complexity of the metrics and really define them. He said it is easy to get the data if the state knows the rules and creates a format to submit them.

5. Council process and outputs

The Council reviewed the Roadmap and Timetable (see Roadmap here). The plan is to consolidate measures at the December 10th meeting. The Care Experience Design Group will not have its recommendations in time for that meeting but they will have the Pediatric Design Group's recommendations. Daniela Giordano said that, given the expanded scope of the Behavioral Health Design Group to look at PCMH standards, it was not realistic for them to have behavioral health recommendations by the 10th. She requested having until January 6th. Dr. Schaefer asked that they distribute their recommendations 10 days in advance of that meeting. Dr. Schaefer said the Health Information Technology Council will propose using edge server technology to collect data. The HIT Council will base their work off of the Quality Council's recommendations.

There was discussion regarding the process for review by the Care Management Committee of the Council on Medical Assistance Program Oversight. Ms. Murphy said she was concerned they would not review the core measurement set and there would not be sufficient time for feedback from the Medicaid advocacy community. Dr. Schaefer said the Care Management Committee will convene after the Thanksgiving holiday and his hope is they will focus on the core measurement set. They expect their review process will be complete in January and that they will work in parallel with the Quality Council once they have completed their review.

There were concerns raised about the review process. The proposed process is for each stakeholder group to review the measures and come back to the larger group with recommendations. The Connecticut Health Foundation has offered to facilitate work for the consumer advocates with an expert. After each group completed their reviews, they would converge and review all three perspectives. Dr. Schaefer noted the downside to this approach is there is a possibility of dividing into fierce camps. Ms. Murphy said that was her concern as she thought they should work collaboratively. She noted that the consumer advocates do need to do some background work so that they are able to make recommendations. Ms. Rexford said the work groups could do the pre-work necessary to complete the tasks ahead. Steve Wolfson said the physicians needed help understanding the measures as well. He said he did not anticipate that any of the groups would impose their positions on everyone. Dr. Staub suggested they focus on measures that are clinically important for a medical home and can be acted upon. They can migrate over a period of time. Dr. Schaefer said the idea is to get to a common measurement set but not necessarily dictate what is in every contract. They aim is to move forward on health equity and care experience. He said that in his discussions with the payers, they customize their measures based on quality gaps. The Council has not discussed flexibility in the measurement set.

Elizabeth Krause suggested they use a consistent format for their recommendations. She also advised that the Council establish a "parking lot." Dr. Schaefer said that they have a spreadsheet they can work from. The Program Management Office can tune the spreadsheet so that they include NQF reference numbers and brief summaries. Dr. Wolfson asked whether they would meet again prior to the next meeting on December 10th. Ms. Krause said that having an extra week would get them to a better product. Ms. Rexford said they could work on December 10th as well. Ms. Murphy suggested they use December 17th as an overflow meeting.

6. Adjourn

The meeting adjourned at 8:10 p.m.